State Initiatives and Opportunities for Community Partnership

King County Health and Human Services Transformation Panel

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This is a time of change marked by multiple, complementary, state efforts

1. Implementation of Health Homes
2. HealthPathWashington comprehensive managed care pilots in King and Snohomish Counties
3. Expansion of Medicaid eligibility
4. State Innovation Model (SIM) Initiative
5. Legislative direction to achieve common outcomes in SB5732 and HB1519

What are Health Homes?

- Available to people with chronic illnesses enrolled in Medicaid or in both Medicare and Medicaid
- Must also be at high risk for health problems that can lead to unnecessary use of hospitals, emergency rooms, and other expensive settings such as psychiatric hospitals and nursing homes
- A predictive risk modeling system (PRISM) identifies individuals who are at significant risk
- Enrollment is voluntary
- Health Homes will be rolled out in 2013, region by region

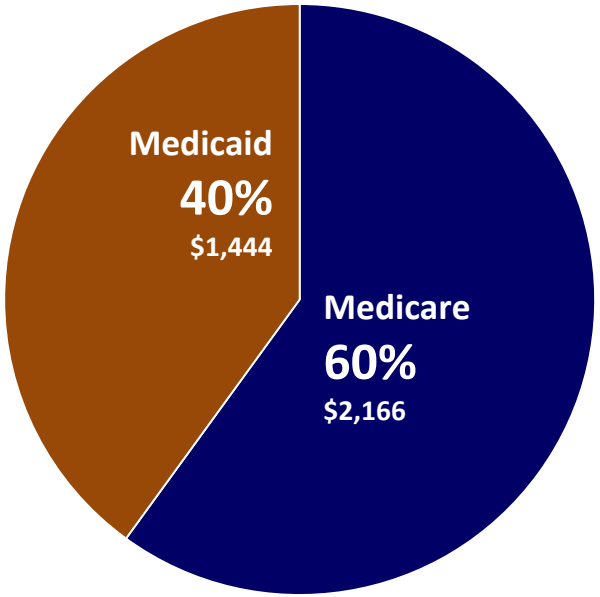
Focusing on those at high risk maximizes potential for return on investment

HIGH RISK DUALLY ELIGIBLE
PER MEMBER PER MONTH, SFY 2010

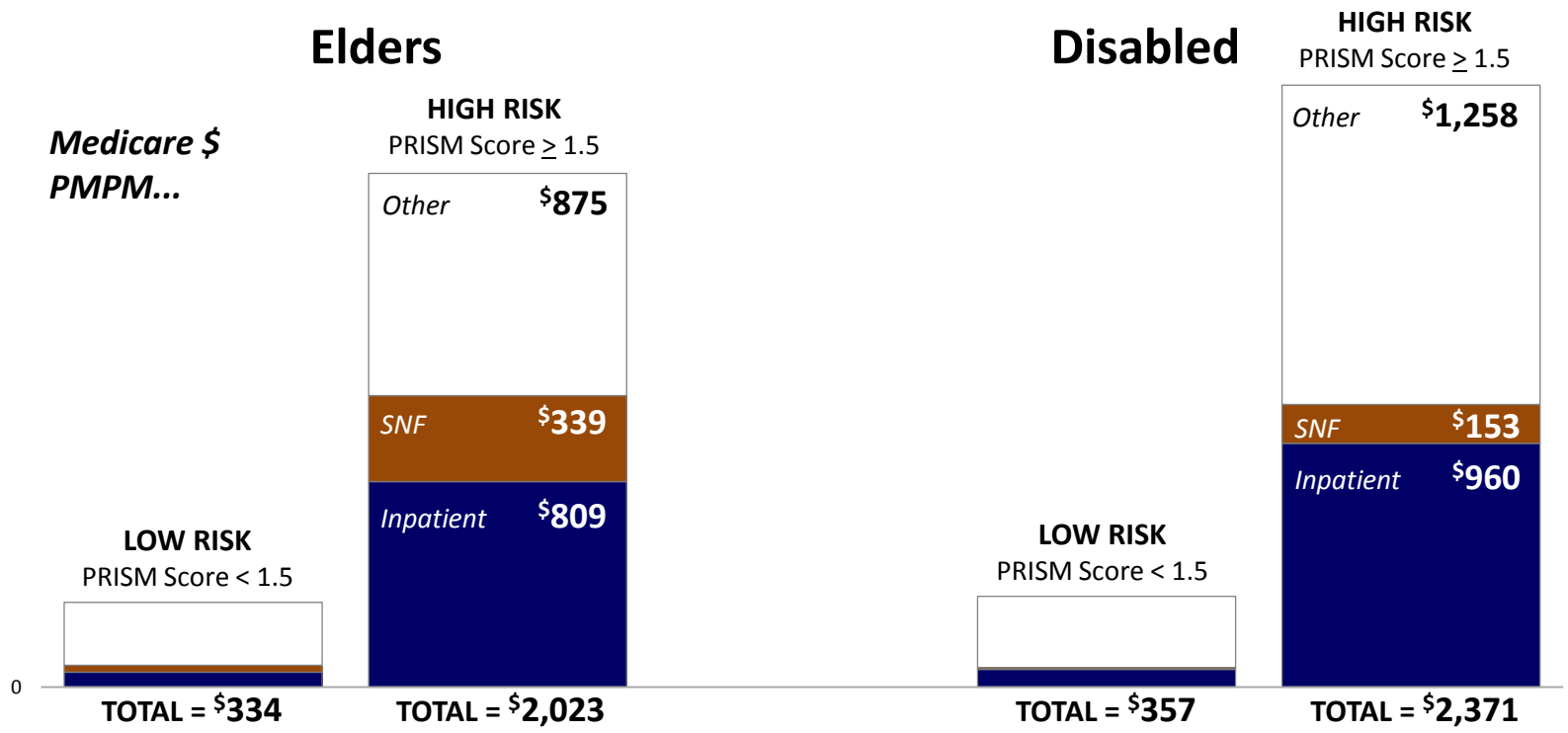
SERVICE CATEGORY	Medicaid FFS	Medicare FFS	TOTAL
Hospital Inpatient	$11	$871	$882
Hospital Outpatient	$21	$266	$287
Physician/Professional	$72	$338	$410
Pharmacy *(Part D imputed at Medicaid paid amount)*	$18	$361	$379
Nursing Facility	$596	$262	$858
HCBS/Hospice/Home Health Care	$650	$68	$718
Mental Health/Substance Abuse	$77	N/A	$77
TOTAL	**$1,444**	**$2,166**	**$3,610**

Medicaid/Medicare Split

PER MEMBER PER MONTH



Risk models identify patients with the most potentially avoidable adverse health outcomes



SFY 2010 *Excludes Medicaid Expenditures*	Medicare Costs Per Member Per Month (PMPM)			
	ELDERS		DISABLED	
	Low Risk PRISM Score < 1.5	High Risk PRISM Score ≥ 1.5	Low Risk PRISM Score < 1.5	High Risk PRISM Score ≥ 1.5
Total PMPM	**$334**	**$2,023**	**$357**	**$2,371**
Inpatient PMPM	$59	$809	$70	$960
SNF PMPM	$27	$339	$7	$153
Covered Lives	46,241	28,703	39,560	20,117

What services will Health Homes provide?

- Health home enrollees will be assigned to a coordinator who will work with beneficiaries, families, doctors, and agencies to ensure coordination across multiple service systems

- The health home coordinator will help the individual, their families, and service providers to:
  - Identify health risks and referral needs
  - Set health improvement goals
  - Improve management of health conditions through education
  - Make changes to improve beneficiaries' ability to function
  - Successfully transition from hospital to other care settings
  - Access the right care, at the right time and place

- The health home coordinator will often be from a place the individual already has a relationship with, such as their doctor's office, community mental health agency, tribal clinic, area agency on aging, or other community based provider

HealthPathWashington Strategy 2 a comprehensive managed care pilot

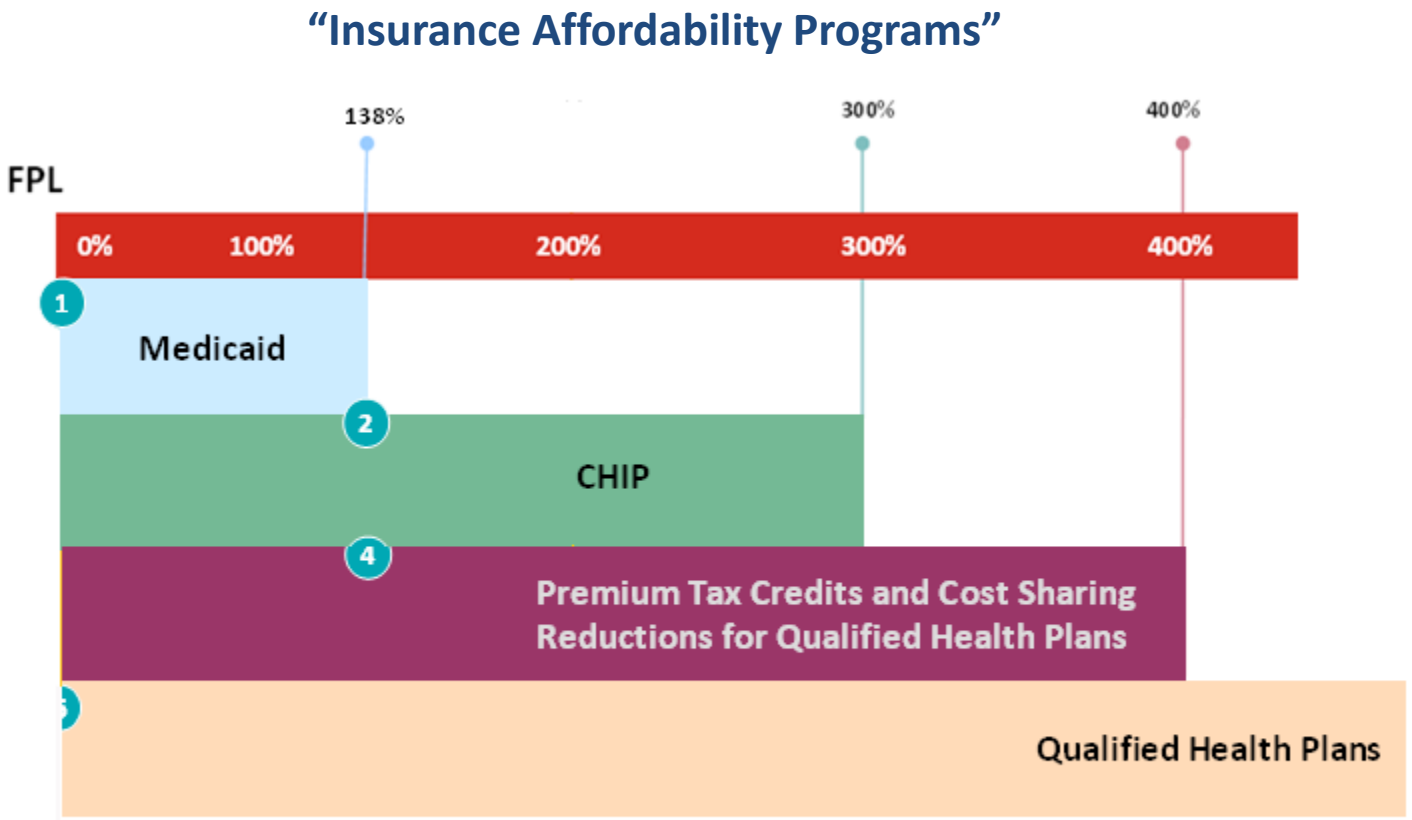
- Washington will implement a three-year managed care demonstration in April 2014 for people who are dually eligible for Medicare and Medicaid in King and Snohomish counties

- DSHS and HCA will jointly administer the demonstration, which also requires agreement from local government

- The demonstration will use a full-risk managed care model that includes Medicare and Medicaid medical services, behavioral health services, long-term services and supports

- Key objectives are to:
  - Support beneficiary access to person-centered care
  - Promote independence, including the ability to self-direct care
  - Eliminate cost shifting
  - Achieve cost savings through better care and coordination.

Medicaid expansion will be part of a broader continuum of healthcare coverage in 2014



Federal Basic Health Plan Option for individuals with incomes between 138% and 200% of the FPL will not be available in 2014.

New Medicaid enrollees will mostly be adults

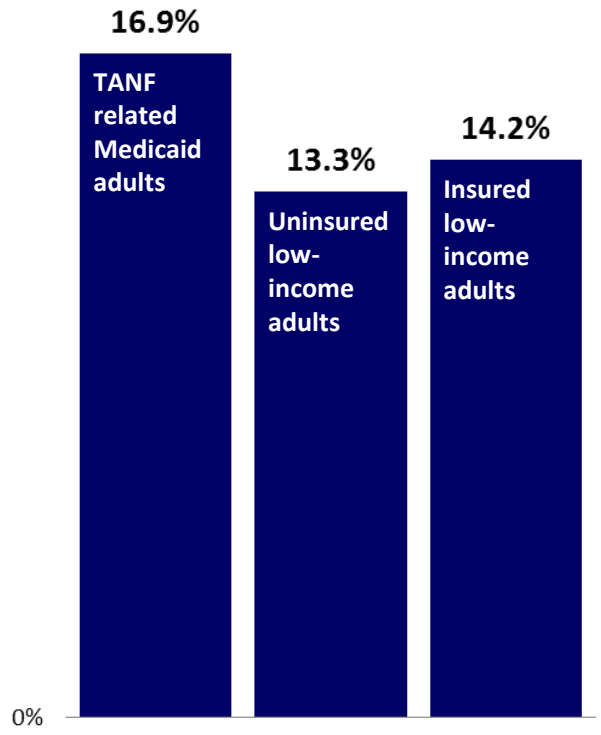
	Eligibility of Projected New Enrollees					
	Currently Eligible, Not Enrolled		Newly Eligible		Total	
	N	%	N	%	N	%
Total	77,913	100.0%	250,308	100.0%	328,221	100.0%
Age						
0 – 18 years	49,115	63.0%	5,512	2.2%	54,627	16.6%
19 - 24 years	2,400	3.1%	80,037	32.0%	82,437	25.1%
25 - 44 years	23,281	29.9%	75,553	30.2%	98,834	30.1%
45 - 64 years	3,117	4.0%	89,206	35.6%	92,323	28.1%

Most new enrollees will have good health but a significant number will not

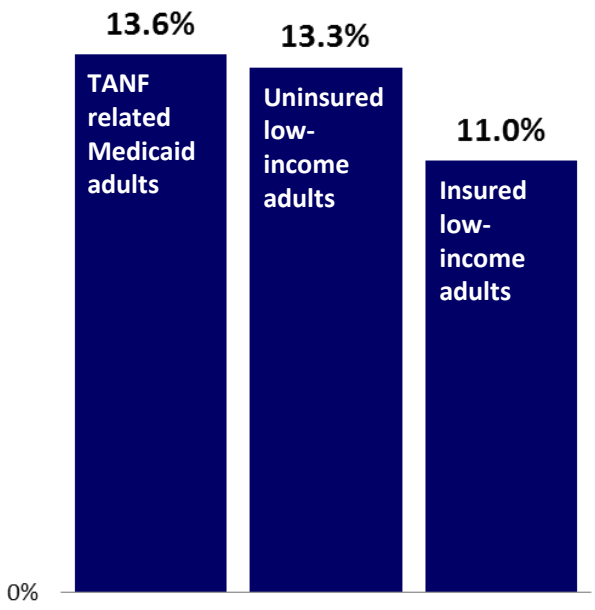
	Eligibility of Projected New Enrollees					
	Currently Eligible, Not Enrolled		Newly Eligible		Total	
	N	%	N	%	N	%
Total	77,913	100.0%	250,308	100.0%	328,221	100.0%
Health Status						
Excellent - Good	58,726	75.4%	180,407	72.1%	239,133	72.9%
Fair - Poor	19,187	24.6%	69,901	27.9%	89,088	27.1%

Low income adults brought into coverage will have rates of behavioral health need comparable to already-insured populations

Moderate to Severe Mental Illness



Substance Abuse/Dependence



What is the State Innovation Model (SIM)?

- A six-month planning effort to develop a state health care innovation plan to accelerate the integration of physical and behavioral health care

- Will transform administration, delivery and payment systems to allow Medicaid purchasing power to drive multi-payer reform

- Key aims include:
  - **Pay for value and improved outcomes** through aligned multi-payer activities.
  - **Achieve seamless, integrated physical and behavioral health care** from the patient's perspective, with initial focus on Medicaid populations.
  - **Speed identification and adoption of effective strategies** aimed at overuse, misuse and underuse of care.
  - **Strengthen health promotion and prevention capabilities,** and partnerships between community services and health care providers.
  - **Improve and make visible health plan and provider performance** through metrics, accreditation, and public reporting for safe, accessible, effective care

The SIM schedule of deliverables is tight

May 1 – Stakeholder Engagement Plan

July 30 – Health Care Innovation Plan (HCIP) Outline, Project Progress & Financial reporting

September 30 – Final Draft HCIP

October 30 – Final HCIP due, Project Progress and Financial Reporting

December 30 – Final Project Report

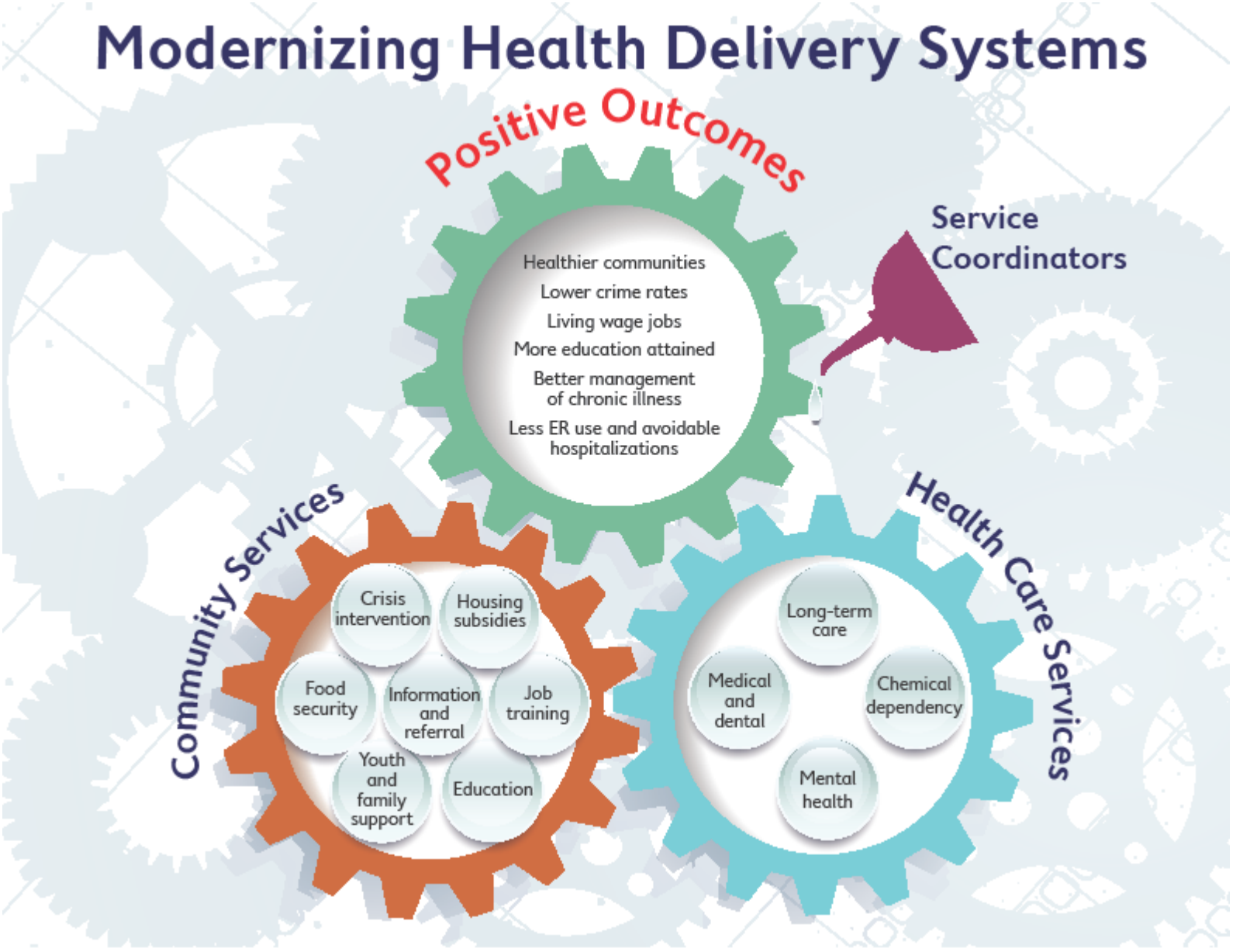
SB5732 and HB1519 direct all systems to common outcomes

- HB1519 directs HCA and DSHS to identify accountability measures by September, 2014 for their contractors to accomplish specified outcomes

- Those measures are to be included in contracts by July, 2015

- The outcomes are established in law:
  - Improved health status and wellness
  - Increased participation in meaningful activities
  - Reduced involvement criminal justice
  - Reduction in avoidable utilization of and costs associated with hospital, emergency rooms, crisis services, jails and prisons
  - Increased housing stability in the community
  - Improved client satisfaction with quality of life
  - Decreased population level health disparities

Modernizing Health Delivery Systems



What opportunities do these initiatives present for community partnership?

Thoughts, questions and comments?